APPENDIX 7
PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT (PA/PA) SAMPLE

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/PA

PRIOR AUTHORIZATION PHYSICIAN ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Ima	A	1234567890	84

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
I. M. Provider	65432187	(XXX) XXX-XXXX

(9) REFERRING/PRESCRIBING PHYSICIAN'S NAME: I. M. Physician, M.D.

A. Describe diagnosis and clinical condition pertinent to service or procedure requested:

Patient is an 84-year old male who suffers from fractured hip and severe arthritis. Is medically stable but unable to walk or sit upright for long periods of time. Patient requires ambulance transportation to geriatric facility in prone or semi-reclining posture.

B. Describe medical history pertinent to service or procedure requested:

Patient was released from geriatric facility for a family gathering in Upper Peninsula. At the gathering, patient fell and broke his hip. Patient was stabilized and treated at local hospital but the fracture aggravated pre-existing rheumatic discomfort. Patient requires care at the geriatric facility. Patient is receiving 10mg codeine enhanced pain reliever PRN.

C. Supply justification for service or procedure requested:

See Sections A and B for background. Patient cannot tolerate transportation in a sitting position. Cot stretcher required, but no medical treatment will be needed during the trip.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

D. 2/3/93 (Date) L. M. Provider (Requesting Provider's Signature)